and hands. In Prystowsky's report, the Raynaud phenomenon was present in 93 percent and swollen hands in 50 percent of the patients. The clinical feature of generalized soft-tissue swelling of the hands and fingers should be distinguished from sclerodactyly, which is accompanied by hardening and thickening of the skin and subcutaneous tissues. These patients also had other manifestations of connective tissue disease such as arthritis and arthralgia, serositis, generalized lymphadenopathy and alopecia, as pointed out by Prystowsky. A low frequency of renal disease appears to be another characteristic clinical feature which might distinguish mixed connective tissue disease from systemic lupus erythematosus.

The accumulating evidence since 1972 clearly shows that antibody to n-RNP has a wide distribution in different connective tissue diseases and that features of systemic lupus erythematosus, discoid lupus, the Sjögren syndrome and scleroderma as well as rheumatoid arthritis have been observed in varying percentages of patients with mixed connective tissue disease. The real question is whether there is a clinical entity called mixed connective tissue disease. This question might be approached if investigators use both serologic as well as clinical markers to exclude patients with other connective tissue diseases. Clearly, patients with lupus and scleroderma have characteristic profiles of autoantibodies, and it is now possible with the aid of well-characterized serologic markers to identify and separate out systemic lupus erythematosus, progressive systemic sclerosis and, probably, other connective tissue diseases. There is precedence for the use of exclusions to classify connective tissue diseases, as exemplified in the American Rheumatism Association diagnostic criteria for rheumatoid arthritis.[7] There are indications that after overlap connective tissue diseases are separated out, there is an unusual group of patients who have high titers of antibody to n-RNP and whose clinical features do not fit into other classic connective tissue diseases. The practical importance of deciding this question is that a large percentage of these patients appears to respond well to the judicious use of corticosteroid therapy.

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Human Nature and Monetary Inflation

THERE IS growing evidence that the monetary inflation in this country has begun to feed upon itself. As wages and prices increase with inflation so do the dollars collected by government through such things as personal income, corporate and sales taxes. This produces little incentive for our public servants, whether elected, or appointed, or just plain hired, to reduce government spending even though this is generally believed to be a significant cause of the monetary inflation which seems to be getting out of hand so rapidly.

When one thinks about it, it seems obvious enough that there is a real conflict of interest for our public servants which has received relatively little attention. In or out of government human nature is much the same. One can therefore easily understand that our public servants, being human, are not likely to be very highly motivated to restrain or curtail the hand that feeds them, especially when it is feeding them rather well, and especially when what needs to be done is not necessarily going to be in the public servants' personal or bureaucratic interest—except to the extent they are all taxpayers and thus subject to the same economic pressures as are the rest of us.

It would seem that this conflict of interest is genuine, far-reaching in implication, and yet to be faced squarely. Conflict of interest has been made a big issue in many aspects of government, but so far not in this. But perhaps it is better that we not yet judge our public servants too harshly in this matter since we all share the same human nature—which we all know has yet to be perfected.

—MSMW